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ABSTRACT

A frequent complaint about the quality of health care delivery is that physicians often do not listen to their patients in consultation sessions. Studies indicate physicians show a tendency to listen only to patient discourse that the examiners had initiated, and to ignore questions and comments that the patients had initiated: that physicians argue with patients over the clinical meaning of descriptors used by patients: that physicians spent more time talking to infants rather than to the infants' mothers: and that the average physician spends very little total time listening to patients. Among the reasons cited for this lack of listening are the physicians' uncertainty about the diagnosis made, difficulty in listening to persons who do not share their level of medical expertise, or the impossibility of living up to the unrealistic expectations made by the patients. A communication course that could be built into the curricula of medical colleges should include such goals as (1) increasing the competencies the physician brings to the interview scene: (2) reducing feelings of threat: and (3) equipping the physician with techniques that allow the patient to solve the dilemmas that infuse the interview. (HOD)

TEACHING LISTENING COMPETENCIES TO PHYSICIANS: Introduction To Tracking Behavior

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A frequent complaint patients voice about the quality of health care delivery is that physicians often do not listen to their patients in consultation sessions. This paper will search communication literature for documentation of this assertion, will examine the reasons health professionals cite for this apparent reluctance to attend patient discourse, and will propose a method for teaching listening competencies to health professionals.

The assertion that physicians are reluctant to attend to patient discourse has been verified by direct observations of physician-patient consultations. Physicians, video taped during diagnostic consultations,[1] showed a tendency to listen only to patient discourse which the examiners had initiated, and to ignore questions and comments which the patients had initiated. The physicians often interrupted their patients in the midst of questions and styled their own questions to elicit a closed "yes" or "no" response from the patients. A number of physicians in this study engaged in challenge questions: "Wait a minute. I thought you told me that you had pain when you wore your glasses. Then why did you just now tell me that your glasses didn't give you a headache?" The physicians frequently argued with patients over the clinical meaning of descriptors used by patients: "Was that a pain or a discomfort?" Such meanings, while significant for the physician, were oblique for the patient. The physicians in this study appeared to listen to their patients only when the patient spoke the practitioner's specialized jargon and accepted the physician's role of dominant initiator of discourse in the consultation.

A larger study[2] (N=800), which observed the interaction among mothers, their children, and their physicians at a pediatric hospital, showed that physicians spent more time talking to their infant patients than to the infants'

mothers. Many physicians gave instructions to the mother by speaking through the child:"Tell your mommie to change your bandage every day." Many physicians in this study showed little interest in the mother's concern for the child and seemed to focus exclusively on the child's ailment. Many of the physicians in this sample ignored and disconfirmed questions or topics voiced by the mothers of the patients.

The literature also indicates that the average medical practitioner spends very little total time listening to his patients. Diagnostic, prescriptive, and listening activities must be compressed into short span of interaction in order for a physician to carry an average case load. The average time that general practitioners spend with each patient is thirteen minutes.[3] Physicians appear to be dominant in directing patient discourse. Consultation time devoted to patient-initiated discourse appears to be held to a minimum. By contrast, many physicians who spend more time than they intended with patients, used the time to argue the wisdom of their prescription or in disputes with patients about alternative interpretations of the prognosis. The more time these physicians devoted to this type of clarifying discourse, the more irritated they became.[4] Short consultation encounters and physician defensiveness would appear to preclude effective listening.

The literature cites a variety of reasons for a physician's alacritous dominance and disconfirmation in patient interaction. Listening pathologies may arise from the physician's uncertainty about his diagnoses. With many conditions such as cancer or the chances of success in surgery, the physician can give only approximate answers to his patients' questions. In many cases, diagnostic precision is impossible. The physician, uncomfortable in these diagnostic

scenes, may assume that his patient will interpret his reticence to discuss prognoses as a sign of medical incompetence instead of prudence. Since the health professional feels uncomfortable in this ambiguous scene, he avoids listening to the patient who is caught in the midst of it.[5] The physician or nurse who listens attentively to a patient with uncertain prognosis, may be required to disclose the limits of his/her medical competence.

Many health professionals find it difficult to listen to persons who do not share their level of medical expertise. The physician often becomes impatient with persons who are anatomically naive and who attribute disease causation to untenable sources. The physician thus may avoid attending the discourse of these persons because he perceives that he would waste his time instructing such patients. Physicians appear to have few skills which enable them to recognize the ability of their audience to understand medical explanations.[6]

The physician may be reluctant to attend to patient discourse because of the practitioner's psychological need to make the patient dependent on his medical knowledge and skill. Information becomes power for the physician because the patient perceives such information as the key to his future health. The patient acknowledges that power and complements the physician's role with a submissive role. Thus the patient must stay in the physician's "good graces" to receive information about his condition. By not attending his patient's discourse the physician creates a dependent patient.[7]

Further, a physician may want to avoid listening to a patient who may perceive him as an unwelcome bearer of bad news,[8] as a counselor who is uncomfortable with intimate secrets of a patient's private life,[9] or as chief medical representative of the hospital who must defend the actions of his peers.[10]

Finally, the physician may find it impossible to live up to the unrealistic expectations his patients may hold of him as a kindly friend who can adroitly summon any resources to meet any misery of man. Such unrealistic expectations are often articulated by the media.

> The role of the medical doctor on television is therefore that of a powerful almost omnipotent healer who performs his duties above and beyond normal expected capacities. He does so in situations that are exciting or controversial and he deals with not only the physical but also the emotional needs of his patients. If he just followed rules, or left private matters to the patients themselves, or did not risk life, limb, love, or money, things would never work out.[11]

Though the reasons for medical inattention may appear plausible to the physician, such behavior appears to spawn a host of pathologies which make the practitioner-patient interaction dysfunctional. Inattention may engender patient hostility. The patient may be provoked to vent this hostility by suing the physician with a host of extraneous proofs of culpability.[12] The physician[13] or nurse[14] may believe that the patient is about to begin litigation against the health professional. This condition of implied threat causes the practitioner to focus even more strongly on the data content of patient discourse and to mask out the affective messages the patient may be sending. The patient who causes a practitioner to doubt his own medical competence[15] may engender derogatory labels[16] and stereotypic classifications[17] from the physician. These negative physician attitudes may further diminish listening receptiveness.

Obviously, the physician could benefit from communication instruction which would increase the effectiveness of his attending competencies. From the review of literature and from field interviews with physicians, the researchers would summarize physicians' listening competencies in the following ways. (1) Physicians

appear to use a limited number of responses when attending to patient discourse. (2) These limited responses may generate feelings of threat for the physician when he encounters patient questions which exceed his repertoire of responses. (3) The physician attempts to reduce this frustration by attending only to the "data" content of the patient interview and by masking the affiliative content of the patient's discourse. (4) This interview strategy neglects an important component of the patient's discourse. This neglect generates feelings of threat in the patient. (5) Physicians view the interview as a scene for information reception; the patient views the interview as a negotiation scene. Communication courses which focus on these pathologies could be built into the curricula of medical colleges and nursing schools. The course offered below could be used as a part of an existing course in medical communication, or could be an in-service training course offered to hospital personnel.

The goals of such a course should grow out of the needs which the health professional experiences in his/her practice. The goals would be: (1) To increase the competencies which the physician brings to the interview scene. Just as a physician is equipped with a wide variety of technical devices for the analysis of disease, he should also have a large number of probe techniques by which he could analyze patient discourse. (2) To reduce feelings of threat which may arise in the interview scene. A course in listening should enable the physician to recognize why he feels defensive in the interview scene and to recognize that as a result of this defensiveness he masks important data the patient may be sending him. (3) To equip the physician with techniques which allow the patient to solve the dilemmas which infuse the interview scene. Often the physician assumes that he is the solution-giver in a counseling scene and that the

patient is a solution-receiver. Such a role characterization excuses the patient from active involvement in the consultation and requires the physician to carry an unrealistic and unproductive work load in the helping relationship. (4) To lead the physician to the realization that the interview is a negotiation scene and not a question and answer period.[18] When the physician realizes that negotiations carry incipient conflict, he will approach the consultation with fewer unrealistic expectations of "avoiding conflict."

The goals of such a listening course would be operationalized by the following session plans.

SESSION I: The students would be introduced to the concepts of threat, defensiveness, discourse as negotiation, selective perception, and probes which enhance perception. Selections from the Ivey and Authier text, Microcounseling[19] would be used for a supplement to the lecture. Listening would be defined as that behavioral evidence which the physician gives to the patient that he is attending to what the patient has disclosed. The students would be introduced to the verbatim technique of data gathering which they would use in later sessions.

SESSION II: Students would be shown video tapes of physicians interviewing patients. These tapes can be made at the hospital by the use of consultation rooms equipped with one-way viewing windows. In viewing the tapes, the class would be asked what topics the physicians in the tapes appeared to be avoiding in their interviews and what nonverbal evidence the students observed of inattention on the part of the physicians. The students would be asked what effect this avoidance of topics had on the patient. The students would be asked to write probes which they think would increase the effectiveness of the interview which they had just seen.

SESSION III: The students would now try out the probes they had written by becoming the interviewers in the taping consultation rooms. Each student would record one interview with a patient. In this interview the student would attempt to utilize appropriate probes to facilitate the interview. The tapes would then be played before the class for the class' comment. The goal of this session is to lead the student to the awareness that questions and probes alone are not a sufficient technique for engendering a supportive consultation climate. As a resolution to this felt need, the concept of tracking behavior is introduced. This concept is defined as that listening behavior which tells the client that the physician is attempting to follow the patient's mind-set and resulting discourse. Specific competencies of tracking behavior are then introduced with video taped models of each component. Components of tracking behavior include:

ISLANDS: topics of discussion which the patient introduces into the consultation. An island contains constellations of attitude/belief structures which are powerfully salient to the patient. By listening to the construction of each island, the physician can gain a picture of that patient's motivational structure. The patient may introduce several islands throughout the consultation. The physician's response to the introduction of a new island guides the patient's predictions about the depth of the interview. The responses which the physician gives to the introduction of a new island will give the patient a prediction of the physician's value judgment of the topic. Thus by his responses, the physician may be telling the patient which are "safe" topics and which are "unsafe" topics for the consultation.

RESPONSE LAG: Most health professionals and counselors make too rapid a response to a patient. By rapid responses, the patient's participation in the

problem-solving situation diminishes. The effective counselor consciously expands the time between when the patient ceases speaking and when the counselor responds. This increase of silence increases the patient's willingness to explore the topic he has introduced.

OPEN QUESTIONS: These types of questions increase, rather than decrease the attitude articulations by which the patient may describe his ailment. In order to be able to ask appropriate open questions, the physician must listen to the quality of the patient's immediate past statement. How questions are appropriate with patient statements of process and feeling. What questions are appropriate with fact statements. Since fact and emotion are fused in patient discourse,[20] it is necessary for the physician to be able to separate these components of the discourse. When the health professional can recognize and listen to both levels of meaning in the interaction he can create responses appropriate to the patient's statements.[21] Why questions are appropriate for statements of activity. Could or would questions are appropriate for statements that show the patient exploring the consequences of his actions.

ENCOURAGERS: are those comments which are spliced into the patient's discourse by the practitioner which urge the speaker to continue his direction of discourse. Encourages are most often needed in the middle of the consultation island when the patient needs encouragement to explore fully the content of the topic he has introduced. An encourager is not a random "uh huh" or "yes, go on." Encouragers are specific remarks that must be attached to the "ticket" or salient attitude expressed in the last sentence the patient has spoken. If the ticket is not correctly identified by the physician, the discourse will tend to halt as the patient abandons one island and searches for another topic. By not

listening, the physician may interrupt effective expression on the part of the patient.

FEELING REFLECTORS: are those responses which show the patient that the counselor is supportive of the feelings he has expressed. Reflectors may be used in response to patient expressions of inadequacy.

FOCUSING: The response which centers on the patient and not the problem that is expressed in the consultation. When the physician focuses on the patient, he enables the patient to affirm his own control of the dilemma before him. When the physician focuses on the problem, however, he disconfirms the patient salient attitudes toward the dilemma. An example of problem focus would be:

Patient: My wife just left me and I don't know what to do.

Physician: Where do you think she went?

An example of patient focus would be:

Patient: My wife just left me and I don't know what to do.

Physician: You feel helpless when she's gone.

PARAPHRASING: those responses which enable the patient to move ahead to a conclusion in the problem solving scene. Often the patient will hesitate to draw a conclusion to his dilemma based on what he has told the physician. By appropriate paraphrase, the physician can encourage the patient to move to the conclusion which he himself finds the most productive. The appropriate paraphrase must enumerate the sub-topics the patient himself has mentioned in the course of the interview. The main headings that the physician uses in the paraphrase must also be lifted from the discourse of the patient. The physician must thus listen for the mode of organization which the patient has used to structure his problem before him.

SUMMARIZATION: At the conclusion of the interview, the physician paints a picture of the entire counseling event which he and the patient have encountered. By the summarization, the physician describes the patient's conclusions drawn from the interview and affirms the patient's ability to arrive at a satisfactory solution. A summarization gives the patient a picture of the progress which he has made during the interview.

SESSIONS IV - XI: During each of these sessions, the instructor will focus on one of the eight competencies named above. In each session, a student will interview a volunteer "patient" for five minutes. These patients can be drawn from a pool of social workers or practicing counselors who work in the hospital environment. The interview will be video taped. After the interview, the instructor and class will discuss the listening competency which is the subject of the session. After the introduction of the competency, a model interview is shown in which the competency is used correctly in a counseling scene. The class will compare the model to the tape made by the student. The instructor will make critique comments on the student's interaction and the class will write correct responses to the student's errors of his interview. After a class rehearsal of correct responses, a new "patient" volunteer is brought to the classroom and is interviewed by a student. The same problem is voiced by this new patient as the taped patient. The students in the class will "fish bowl" this interview, make notes for discussion, and later critique the student.[22]

SESSION XII: The students review the eight competencies surveyed in the course and establish a permanent seminar setting with regular meeting times where they may examine counseling cases they encounter in their practice. In this type of seminar setting, the physicians would be able to present difficult cases

in consultations to their peers and would be able to receive suggestions for the conduct of these cases. By interacting with peers, innovations of response techniques could be explored and listening competencies could be burnished. Physicians frequently hold such seminar sessions when a patient dies within the hospital setting; it would be refreshing to see physicians rennovate their counseling competencies while their patients are still alive.

> The more I am open to the realities in me and in the other person, the less do I find myself wishing to rush in to "fix things." As I try to listen to myself and the experiences going on in me, and the more I try to extend that same listening attitude to another person, the more respect I feel for the complex processes of life.[23]

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